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FISCAL IMPACT STATEMENT

LS 6753

BILL NUMBER: HB 1377

NOTE PREPARED: Jan 17, 2006

BILL AMENDED:

SUBJECT: Transfer of Residential Care Residents.

FIRST AUTHOR: Rep. Lehe

FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X GENERAL
DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: This bill prohibits the State Department of Health from requiring the transfer of a health facility resident receiving residential care to a comprehensive care bed in the health facility if specified conditions are met.

Effective Date: July 1, 2006.

Explanation of State Expenditures: This bill would allow a licensed comprehensive care facility with designated residential beds to provide a more intensive level of care in a residential care-designated bed without moving the patient to a comprehensive care bed. The bill would allow private pay patients to remain in residential beds while receiving comprehensive care from the facility. The Quality Assessment (QA) imposed on nursing facilities is not assessed on residential beds. This provision could reduce the total amount of money collected for the QA, thereby reducing the 20% of the total collection that the state returns to the General Fund. The 80% portion of the QA fee that must be used to leverage federal funding for nursing facility reimbursement would also decrease, while the enhanced payments that are made to nursing homes for special care and report card scores would be unaffected. Funding for this component would be reduced while payment would not, unless the Office of Medicaid Policy and Planning would adjust the add-on payments to reflect lower QA collections.

The provision could increase Medicaid nursing facility reimbursement rates if facilities designate more beds as residential to accommodate private pay patients. Residential beds are not included in the occupancy calculation used to determine the minimum occupancy requirement. By designating existing comprehensive care beds as residential, a facility could artificially increase the occupancy level of the facility which could impact

the allowable fixed capital costs included in the facility's Medicaid rate.

Conversely, the amount of allowable cost claimed for the QA fee would be reduced, which could decrease the Medicaid reimbursement rates paid. How these two factors would impact the final reimbursement would be dependent upon the extent to which existing or converted residential beds might be used to provide comprehensive care for patients avoiding the QA.

The provisions of the bill could also increase survey costs of the Department of Health by increasing the time required for licensure and certification surveys they would perform. Since residential care is not reimbursed by Medicare or Medicaid, increases in survey costs would be 100% state expense. The ultimate cost would be dependent on the extent to which residential beds might be used to provide comprehensive care.

Ultimately, the fiscal impact of this bill will be dependent upon federal approval of the rule revision with regard to the Quality Assessment program and on the extent that facilities might convert beds from comprehensive care to residential care to allow their private pay patients to avoid the Quality Assessment.

Background: The state and the Medicaid program require that all applicants to nursing facilities must participate in the Pre-Admission Screening Program to determine if they meet a specified level of care in order to be admitted to a nursing facility. If an individual does not meet the nursing facility level of care or refuses the screening process, and chooses to be admitted to a comprehensive care bed in a facility, Medicaid per diem reimbursements may be withheld for up to one year. Nursing facilities may designate beds for a lower level of care called residential care, for those persons who need only room and board and some assistance with medications. Medicaid and Medicare do not pay for residential care. Residential care is private-pay patient business for a nursing facility or a residential care facility unless the residential beds are designated as participating in the state's Residential Care Assistance Program (RCAP).

Current State Department of Health (ISDH) rules, with certain exceptions, allow a resident of a licensed residential care facility to stay in the facility if the residential care facility has a licensed provider provide the comprehensive care. A home health agency, hospice, or private-duty nurse might be providers that could provide the additional care necessary. A licensed nursing facility with designated residential care beds may also arrange to have an outside licensed provider deliver the additional care the patient needs. The ISDH rules require the transfer of residential care patients to comprehensive care beds due to the patient's need for higher levels of nursing care unless outside arrangements to deliver the additional needed care have been made. This bill would allow the facility to provide the additional care necessary.

Explanation of State Revenues: This bill would allow a licensed comprehensive care facility with designated residential beds to provide a more intensive level of care in a residential care-designated bed without moving the patient to a comprehensive care bed. The bill would allow private pay patients to remain in residential beds while receiving comprehensive care. The Quality Assessment (QA) is not assessed on residential beds. This provision could reduce the total amount collected for the QA, thereby reducing the 20% share of the collection that the state returns to the General Fund. The 80% portion of the QA fee that must be used to leverage federal funding for nursing facility reimbursement would also decrease.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: State Department of Health; Office of Medicaid Policy and Planning.

Local Agencies Affected:

Information Sources: State Department of Health; Myers & Stauffer; Indiana Administrative Code.

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